LABOR ACTIVITY REPORT

DEPARTMENT OF HEALTH SERVICES

PAY PERIOD _____ TO _____

TIMEKEEPER'S INITIALS _____

TELEPHONE NUMBER _____

NAME _____ SOCIAL SECURITY NO. _____ DATE _____

PERCENT	AY	PCA	INDEX	S	S	M	T	W	T	F	S	S	M	T	W	T	F	TOTAL
TOTAL HOURS WORKED																		

	ANNUAL LEAVE	VT																
	SICK LEAVE	ST																
	HOLIDAY	SH/HT																
	COMP. TIME USED	CT																
	JURY DUTY	DT																
	MISCELLANEOUS LEAVE																	
	Short Term Leave w/o Pay	LW																
TOTAL LEAVE HOURS																		

PAY PERIOD TOTALS																

I certify that the hours above represent, to the best of my knowledge, an accurate record of the time that I have devoted to the identified programs/activities as per ADHS policies and procedures.

EMPLOYEE'S SIGNATURE _____

SUPERVISOR'S SIGNATURE _____

ADHS/D-10(Revised 2/00)